		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045369

Facility Name: ManorCare of Highland Park

Address: 2773 Skokie Valley Road (Number) Highland Park (City) 60035 (Zip Code)

County: Lake

Telephone Number: (847) 266-9266 **Fax #** (847) 266-9240

IDPA ID Number: 520886946-024

Date of Initial License for Current Owners: 6/15/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419-252-5740)

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	215	Skilled (SNF)	215	78,690	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,690	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,168	8,808	8,163	32,139	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,168	8,808	8,163	32,139	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.84%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/10/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/15/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 208 and days of care provided 7,005

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	261,926	15,771	6,490	284,187	2,917	287,104		287,104			1
2	Food Purchase		150,916		150,916		150,916	(1,357)	149,559			2
3	Housekeeping	151,804	19,341	1,799	172,944		172,944		172,944			3
4	Laundry	25,966	12,578	2,493	41,037		41,037		41,037			4
5	Heat and Other Utilities			197,047	197,047	6,728	203,775		203,775			5
6	Maintenance	50,483	32,853	65,651	148,987		148,987		148,987			6
7	Other (specify):* Med Waste Utilities			2,127	2,127		2,127		2,127			7
8	**TOTAL General Services**	490,179	231,459	275,607	997,245	9,645	1,006,890	(1,357)	1,005,533			8
	B. Health Care and Programs											
9	Medical Director			28,305	28,305		28,305		28,305			9
10	Nursing and Medical Records	1,981,010	157,396	84,350	2,222,756	49,745	2,272,501	(1,584)	2,270,917			10
10a	Therapy	402,856	11,191	51,895	465,942		465,942		465,942			10a
11	Activities	88,213	6,304	2,805	97,322		97,322		97,322			11
12	Social Services	86,827	264		87,091		87,091		87,091			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,558,906	175,155	167,355	2,901,416	49,745	2,951,161	(1,584)	2,949,577			16
	C. General Administration											
17	Administrative	107,591		390,597	498,188	(125,014)	373,174		373,174			17
18	Directors Fees											18
19	Professional Services			19,105	19,105	(3,910)	15,195		15,195			19
20	Dues, Fees, Subscriptions & Promotions			73,735	73,735		73,735	(24,418)	49,317			20
21	Clerical & General Office Expenses	266,069	57,482	96,794	420,345	3,910	424,255	(58,562)	365,693			21
22	Employee Benefits & Payroll Taxes			601,852	601,852	45,733	647,585		647,585			22
23	Inservice Training & Education			9,286	9,286		9,286		9,286			23
24	Travel and Seminar			8,271	8,271		8,271		8,271			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			195,791	195,791		195,791		195,791			26
27	Other (specify):*											27
28	**TOTAL General Administration**	373,660	57,482	1,395,431	1,826,573	(79,281)	1,747,292	(82,980)	1,664,312			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,422,745	464,096	1,838,393	5,725,234	(19,891)	5,705,343	(85,921)	5,619,422			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ManorCare of Highland Park #0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			505,463	505,463	19,891	525,354		525,354			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			108,185	108,185		108,185		108,185			32
33	Real Estate Taxes			114,053	114,053		114,053	(95,094)	18,959			33
34	Rent-Facility & Grounds			1,295,840	1,295,840		1,295,840		1,295,840			34
35	Rent-Equipment & Vehicles			72,334	72,334		72,334		72,334			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,095,875	2,095,875	19,891	2,115,766	(95,094)	2,020,672			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		192,746	16,647	209,393		209,393		209,393			39
40	Barber and Beauty Shops			21,678	21,678		21,678		21,678			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,036	118,036		118,036		118,036			42
43	Other (specify):*		27,880		27,880		27,880		27,880			43
44	**TOTAL Special Cost Centers**		220,626	156,361	376,987		376,987		376,987			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,422,745	684,722	4,090,629	8,198,096		8,198,096	(181,015)	8,017,081			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,032)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,903)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(399)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(50)	21		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(42)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(56,168)	21		24
25	Fund Raising, Advertising and Promotional	(24,418)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(95,094)	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(1,909)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (181,015)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (181,015)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ManorCare of Highland Park

ID# **0045369**

Report Period Beginning: **1/1/2004**

Ending: **12/31/2004**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Revenue	$ (325)	2	1
2	Purchase Service - Dentistry	(250)	10	2
3	Medical Transportation Non-Ambulance	(1,334)	10	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,909)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ManorCare of Highland Park **#** 0045369 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,357)	0	0	0	0	0	0	0	0	0	0	(1,357)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,357)	0	0	0	0	0	0	0	0	0	0	(1,357)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,584)	0	0	0	0	0	0	0	0	0	0	(1,584)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,584)	0	0	0	0	0	0	0	0	0	0	(1,584)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(24,418)	0	0	0	0	0	0	0	0	0	0	(24,418)	20
21	Clerical & General Office Expenses	(58,562)	0	0	0	0	0	0	0	0	0	0	(58,562)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(82,980)	0	0	0	0	0	0	0	0	0	0	(82,980)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(85,921)	0	0	0	0	0	0	0	0	0	0	(85,921)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ManorCare of Highland Park # 0045369 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(95,094)	0	0	0	0	0	0	0	0	0	0	(95,094)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(95,094)	0	0	0	0	0	0	0	0	0	0	(95,094)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(181,015)	0	0	0	0	0	0	0	0	0	0	(181,015)	45

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corp. of America (SEE H.O. COST REPORT)	Toledo, Ohio			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Page 8	Home Office Allocation	$ 390,597	HCR Manor Care, Inc.	100.00%	$ 390,597	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V		10a	Therapy Management	24,550	Heartland Management Services	100.00%	24,550		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 415,147			$ 415,147	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 333 North Summit Street
City / State / Zip Code: Toledo, Ohio 43604
Phone Number: (419-252-5500)
Fax Number: (419-252-5495)

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	$	$	7,909,215	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	1,043,233	571,891	7,909,215	2,917	2
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	223,707		7,909,215	748	3
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,139,042		7,909,215	5,980	4
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	12,987,607	8,226,246	7,909,215	43,448	5
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	2,252,260	1,199,059	7,909,215	6,297	6
7	17	General & Admin - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	16,611,639	15,056,893	7,909,215	55,571	7
8	17	General & Admin - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	75,121,310	43,509,256	7,909,215	210,014	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.	3,924,545		7,909,215	13,129	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	11,662,215		7,909,215	32,604	10
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	369 Nurs. Fac.			7,909,215	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	369 Nurs. Fac.	7,114,804		7,909,215	19,891	12
13										13
14	32	Interest				10,002,527				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 143,082,889	$ 68,563,345		$ 390,599	25

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	National City Bank, Trustee		X	Facility			$ 1,733,736	$			$ 108,360	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Interest Expense Other										(175)	8
9	TOTAL Facility Related						$ 1,733,736	$			$ 108,185	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,733,736	$			$ 108,185	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ManorCare of Highland Park **#** 0045369 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	188,891	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	93,797	2
3. Under or (over) accrual (line 2 minus line 1).	$	(95,094)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	93,797	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	20,256	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	18,959	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000	94,016	9
2001	188,261	10
2002	188,891	11
2003	93,797	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ManorCare of Highland Park COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0045369

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-16-401-005	See Attached	$ 57,026.66	$ 57,026.66
2.	16-16-401-005	See Attached	$ 57,026.66	$ 57,026.66
3.	Tax Appeals	See Attached	$ 20,256.00	$ 20,256.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 134,309.32	$ 134,309.32

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73,108 B. General Construction Type: Exterior Masonry Frame Steel, Fire Resistant Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		2001		$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					371,868		371,868		506,925	9
10	Civil Engineering Services			2001	3,332						10
11	Title survey, environmental site assessment,professional serv.			2001	26,933						11
12	Title survey, environmental site assessment,professional serv.			2001	5,937						12
13	Title survey, environmental site assessment,professional serv.			2001	11,541						13
14	Sinage			2001	2,234						14
15	Sinage			2002	10,967						15
16	Sidewalk			2003	3,496						16
17	Architect & Engineering Fees			2003	78,456						17
18	Developers Costs - Auto & Travel			2003	433						18
19	Developers Costs - Permits Fees			2003	1,195						19
20	Developers Costs - Plan Reviews			2003	6,013						20
21	Developers Costs - Overhead			2003	942,605						21
22	Interest			2003	83,525						22
23	Carpeting & Pads			2003	82,366						23
24	Wallcovering			2003	44,992						24
25	Cubicle Track - Material			2003	240						25
26	Carpentry Subcontractor			2003	905,757						26
27	HVAC			2003	4,180						27
28	Basic Electrical			2003	10,021						28
29	Building Demolition			2003	65,000						29
30	Site Clearing			2003	45,230						30
31	General Contractor			2003	324						31
32	Paving			2003	8,989						32
33	Landscaping			2003	31,494						33
34	Exterior Sign - Site			2003	583						34
35	Legal Fees			2003	44,751						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	VWC	2003	75						38
39	Freight on Carpet	2003	43						39
40	Carpet	2003	359						40
41	Flooring Installation	2003	843						41
42	Architect & Engineering	2003	471						42
43	Doors	2003	3,880						43
44	CONCRETE PAD	2004	885						44
45	CONCRETE PAD	2004	2,620						45
46	LIGHTING FOR FLAGPOLE	2004	4,220						46
47	EXTERIOR LIGHTING UPGRADE	2004	15,820						47
48	EXTERIOR LIGHTING	2004	2,818						48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,452,628	$ 371,868		$ 371,868	$	$ 506,925	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 860,534	$ 133,595	$ 133,595	$		$ 258,770	71
72	Current Year Purchases	63,923						72
73	Fully Depreciated Assets							73
74				19,891	19,891			74
75	TOTALS	$ 924,457	$ 133,595	$ 153,486	$ 19,891		$ 258,770	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,377,085	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 505,463	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 525,354	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 19,891	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 765,695	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1997	215	6/15/01	$ 1,295,840	15	10	3
4	Additions							4
5								5
6								6
7	TOTAL		215		$ 1,295,840 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: See Attached *

10. Effective dates of current rental agreement:
Beginning 6/15/01
Ending 6/15/16

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/2003	$ 1,150,000
13.	12/2004	$ 1,295,840
14.	12/2005	$ 1,400,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 72,334 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A	7914 hrs	$ 213,206	547	$ 13,664	$ 2,177	8,461	$ 229,047	1
2	Licensed Speech and Language Development Therapist	10A	1385 hrs	37,302	87	2,185	324	1,472	39,811	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	5655 hrs	152,348	1,229	30,718	8,690	6,884	191,756	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				192,746		192,746	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Minor Eq Inhalation					5,328			5,328	13
14	TOTAL			$ 402,856	1,863	$ 51,895	$ 203,937	16,817	$ 658,688	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ManorCare of Highland Park **#** 0045369 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (53,953)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (116,734))	884,574		3
4	Supply Inventory (priced at)	61,997		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	753		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 893,371	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,452,628		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	924,456		16
17	Accumulated Depreciation (book methods)	(765,695)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,611,389	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,504,760	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (58,166)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(308,392)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(114,053)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	(91,229)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (571,840)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	(1,733,736)		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	28,549		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (1,705,187)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (2,277,027)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,227,733)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (3,504,760)	$	48

***(See instructions.)**

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,285,013	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,285,013	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,986,474)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,986,474)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(526,272)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (526,272)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,227,733)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,207,525	1
2	Discounts and Allowances for all Levels	(1,293,713)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,913,812	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,033,404	6
7	Oxygen	553	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,033,957	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	367	12
13	Barber and Beauty Care	24,384	13
14	Non-Patient Meals	1,032	14
15	Telephone, Television and Radio	1,903	15
16	Rental of Facility Space		16
17	Sale of Drugs	226,368	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,905	19
20	Radiology and X-Ray	1,418	20
21	Other Medical Services	220	21
22	Laundry	807	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 263,404	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	50	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 50	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	399	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 399	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,211,622	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	997,245	31
32	Health Care	2,901,416	32
33	General Administration	1,826,573	33
	B. Capital Expense		
34	Ownership	2,095,875	34
	C. Ancillary Expense		
35	Special Cost Centers	376,987	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,198,096	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,986,474)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,986,474)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,965	2,123	$ 68,368	$ 32.20	1
2	Assistant Director of Nursing	3,672	3,966	120,376	30.35	2
3	Registered Nurses	24,932	26,930	756,387	28.09	3
4	Licensed Practical Nurses	9,909	10,703	235,311	21.99	4
5	Nurse Aides & Orderlies	59,580	64,355	769,070	11.95	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	13,109	14,201	382,554	26.94	7
8	Rehab/Therapy Aides	1,540	1,668	20,302	12.17	8
9	Activity Director					9
10	Activity Assistants	6,545	7,070	88,213	12.48	10
11	Social Service Workers	4,140	4,462	86,827	19.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,303	22,960	261,926	11.41	15
16	Dishwashers					16
17	Maintenance Workers	2,619	2,780	50,483	18.16	17
18	Housekeepers	12,835	13,871	151,804	10.94	18
19	Laundry	2,251	2,432	25,966	10.68	19
20	Administrator	2,555	2,555	107,591	42.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,015	11,606	202,112	17.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,075	2,245	31,498	14.03	31
32	Other Health C: Program Director	1,129	1,129	15,200	13.46	32
33	Other(specify) Human Resources	2,156	2,156	48,757	22.61	33
34	TOTAL (lines 1 - 33)	182,330	197,212	$ 3,422,745 *	$ 17.36	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	28,305	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 28,305		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,952	$ 54,820	5,10,3	50
51	Licensed Practical Nurses	27	585	5,10,3	51
52	Nurse Aides	9	113	5,10,3	52
53	TOTAL (lines 50 - 52)	1,988	$ 55,518		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Theresa J. Smelser	Administrator	0	$ 24,273
John P. Stare	Administrator	0	83,318
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 107,591

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 390,597
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 390,597

C. Professional Services

Vendor/Payee	Type	Amount
Foote, Meyers, Mielke & Flowers	Legal	$ 14,017
Van Ostrand & Elvidge Kelly	Legal	1,179
Special Consultant	Admin.	3,910
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 19,105

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,803
Unemployment Compensation Insurance	37,150
FICA Taxes	253,644
Employee Health Insurance	223,815
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	6,961
401K	13,573
Other Employee Benefits	(537)
Tuition Program	4,104
Employee Uniform	339
Home Office Allocation	45,733
TOTAL (agree to Schedule V, line 22, col.8)	$ 647,585

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,865
Advertising: Employee Recruitment	26,161
Health Care Worker Background Check	2,676
(Indicate # of checks performed 107)	
Dues & Subscriptions	2,786
Association Dues	6,780
NDAssoc. Dues	3,158
Mktg. Lect. Admin	1,000
Advertising	28,309
Less: Non allowable Assoc. Dues	(3,158)
Less: Public Relations Expense	( )
Non-allowable advertising	(21,260)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 49,317

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,271
Includes travel expense to the Home	
Office in Toledo, Ohio for regional	
Meeting.	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,271

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ManorCare of Highland Park # 0045369 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ManorCare of Highland Park **#** 0045369 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $9,938**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **3158**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **38,766** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **118,036**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,032**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.